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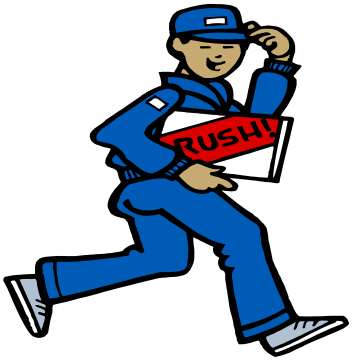

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ENCOUNTER KEYS

JULY-AUGUST, 2006

Just a few reminders and/or clarifications related to AHCCCS Outlier Processing and the documentation currently published by AHCCCS.

The AHCCCS Inpatient Hospital Rates OUTLIER THRESHOLDS FOR CURRENT YEAR is the actual list of what is officially an outlier. This document is distributed annually along with the hospital rate sheets that are typically sent out in advance of October 1 each year. The outlier thresholds on this page represent per day **cost** thresholds that AHCCCS compares to a hospital's derived per day **costs** [(total billed charges multiplied by the hospital's specific cost-to-charge ratio)/days] to determine when an inpatient stay qualifies for outlier reimbursement.

To make things a bit easier on the hospitals, we have given them each their own list of **charge** thresholds as a sort of guideline for what they should flag as outliers. This list is the actual outlier threshold (above) divided by their cost-to-charge ratio, and then rounded down to the nearest 100. The idea is that it gives them a guideline; if they have a claim with **charges** per day over this amount, flag it as an outlier.

Notice that their rate sheet says,

> Guideline **Charge** Thresholds for Inpatient Outlier Payment Consideration: Claims with **charges** per day in excess of the amount presented below for your hospital should be flagged for outlier payment consideration for dates of service . . . .

In the absence of contracts that state otherwise, Health Plans should use the lone OUTLIER THRESHOLD FOR CURRENT YEAR document for outlier determination based on hospitals' derived **costs**.

According to R9-22-712.45, emergency room, observation and other outpatient hospital services provided to the member before a hospital admission are included in the inpatient claim and paid according to the AHCCCS Inpatient Tiered Per Diem methodology.

OP bundling methodology does not apply to inpatient claims.

Please ensure that all encounters for claims requested and paid at outlier contain the 61 flag. Please let us know if you have any questions.

Modifier(s)

- The following codes can be reported with the modifier QW (CLIA Waived).
  83036 Hemoglobin; Glycosylated (A1C) effective with dates of service January 1, 2006
  80178 Lithium effective with dates of service April 22, 2005
  83880 Natriuretic Peptide effective with dates of service August 26, 2005

- Effective with dates of service after January 1, 1994, the modifier MS (Maintenance Service-Rental for 15 months) has been added to K0001 (Standard Wheelchair).

- Effective for dates of service on or after January 1, 2006 the modifiers: QF (Oxygen>Four Liters/Min Plus Portable); QG (Oxygen>Four Liters Per Minute); QH (Conserving Device Is Being Used) have been added to the following codes:

E0443	Portable Oxygen Contents, Gaseous (For Use Only With Portable Gas)
E0444	Portable Oxygen Contents, Liquid (For Use Only With Portable Liquid)
E1353	Regulator
E1355	Stand/Rack
E1390	Oxygen Concentrator, Single Delivery Port, Capable Of Delivering
E1391	Oxygen Concentrator, Dual Delivery Port, Capable Of Delivering 85
E1392	Portable Oxygen Concentrator, Rental
S8120	Oxygen Contents, Gaseous, 1 Unit Equals 1 Cubic Foot
S8121	Oxygen Contents, Liquid, 1 Unit Equals 1 Pound

- Effective with dates of service on or after January 1, 2006 the modifier GT (Telemedicine) can be reported on CPT codes:

  97802 Medical Nutrition Therapy; Initial Assessment And Intervention,
  97803 Medical Nutrition Therapy; Re-Assessment And Intervention,

- Effective with dates of service July 1, 2006 the modifier CA (Procedure Payable Only in Inpatient Setting) cannot be reported with the CPT code K0736 (Skin Protection/Positioning Wheelchair Seat Cushion).

- Effective with dates of service beginning January 1, 2006 the code 90765 Intravenous Infusion, for therapy, prophylaxis or diagnosis can be reported using the following modifiers:

CC	Procedure Code Change
CR	Catastrophe/Disaster
GC	Teaching Physician
Q6	Locum Tenens
59	Distinct Procedural

Revenue Code Update(s)

Effective with dates of service on or after April 1, 2005 the following codes can be reported with Revenue Code 0636 (Drugs/Detail):

Q9945 Low Osmolar Contrast Material, Up To 149 Mg/Ml Iodine Concentration
Q9946 Low Osmolar Contrast Material, 150-199 Mg/Ml Iodine Concentration
Q9947 Low Osmolar Contrast Material, 200-249 Mg/Ml Iodine Concentration
Q9948 Low Osmolar Contrast Material, 250-299 Mg/Ml Iodine Concentration
Q9949 Low Osmolar Contrast Material, 300-349 Mg/Ml Iodine Concentration
Q9950 Low Osmolar Contrast Material, 350-399 Mg/Ml Iodine Concentration
Q9951 Low Osmolar Contrast Material, 400 Or Greater Mg/Ml Iodine Concentration

Code Changes

- PA not required for Acute or Long Term Care for code 36598 (Contrast Injection(s) for Radiologic Evaluation of Existing Central Venous Access Device, Including Fluoroscopy, Image Documentation and Report).

- Effective July 5, 2006 the codes C9229 (Injection, Ibandronate Sodium Per 1 MG); and C9230 (Injection, Abatacept, Per 10 MG) have changed coverage code to Y for Medicare Coverage and the Sex indicator has been removed.

Age Change

- Effective with dates of service on or after April 12, 2006, the CPT code 90633 (Hepatitis A vaccine, pediatric/adolescent dosage-2 dose schedule), for intramuscular use can be administered to children with a minimum age of 1 year.

- Age limit changed from 10-60 to 10-999 years of age for code 58661, (Surgical Laparoscopy; with Removal of Adneral Structure).

HCPCS to Revenue Code

Effective with dates of service on or after January 1, 2006 the revenue code 0333 (Radiation RX) has been added to code 0073T (Compensator-based Beam Modulation Treatment Delivery).

Dental Update Effective with dates of service on or after June 30, 2006 the following list of CDT codes require tooth number, tooth surface and/or oral cavity. The reference screen with this information can be found on RF103.

Dental Codes	Tooth Number	Tooth Surface	Oral Cavity
D1351	Yes	Yes	No
D2140 - D2664	Yes	Yes	No
D2710 - D2999	Yes	No	No
D3110 - D3999	Yes	No	No
D4000 - D4999	No	No	Yes
D6000 - D6999	Yes	No	No
D7111 - D7283	Yes	No	No
D7285 - D7999	No	No	Yes

- The supernumerary tooth numbers have been added to the dental reference tables.

Dental Tooth Code.pdf

Rates

- Hemophilia, Transportation, Dental, Nursing and Home Community Base Services (HCBS) updates for October 1, 2006 can be found at the AHCCCS website:

http://www.azahcccs.gov/RatesCodes

Incontinence Briefs

Updated information regarding incontinence briefs can now be found in the AHCCCS Medical Policy Manual (AMPM) at: http://www.azahcccs.gov/Regulations/OSPpolicy/

Encounters pending for the error code S385 (Service Units Exceed Maximum Allowed) will be overridden when AMPM conditions are met. For any further clarification, refer to the Communications e-mail of 05/04/2006.

Place of Service (POS)

Effective with dates of service July 1, 2006 the CPT codes: 0159T (Computer Aided Detection, Including Computer Algorithm); 0160T (Therapeutic Repetitive Magnetic Stimulation Treatment); and 0161T (Therapeutic Repetitive Transcranial Magnetic Stimulation) can be reported with only the POS below:

05	Indian Health Service Free Standing
06	Indian Health Service Provider Base
07	Tribal 638 Free Standing Facility
08	Tribal 638 Provider Based Facility
22	Outpatient Hospital

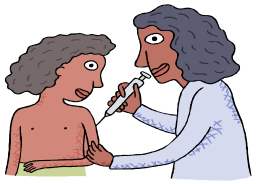
- Effective with dates of service on or after December 1, 2005 POS 22 (Outpatient Hospital), can be reported for CPT code 88142 (Cytopathology Cervical or Vaginal, (any reporting system), collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision).
- Effective with dates of service on or after December 1, 2005 the following codes can be reported with POS 12 (Home):

  E1800 - Dynamic Adjustable Elbow Extension/Flexion Device,
  E1805 - Dynamic Adjustable Wrist Extension / Flexion Device

- Effective with dates of service on or after January 1, 2006 the following code can be reported with POS 11 (Office):

  83037 - Hemoglobin; Glycosylated (A1C) By Device Cleared By FDA

- Effective with dates of service on or after April 1, 2006 the HCPCS code 17110 (Destruction (e.g., Laser Surgery, Electrosurgery)), can be reported at POS 56 (Psychiatric Residential Treatment).



- Effective with dates of service on or after June 1, 2005 the POS 23 (Emergency Room-Hospital), has been added to the following codes:

Code	Description
26075	Arthrotomy, With Exploration, Drainage, Or Removal Of Loose or Foreign Body; Carpometacarpal Joint
92002	Ophthalmological Services: Medical Examination And Evaluation
92004	Ophthalmological Services: Medical Examination And Evaluation
92012	Ophthalmological Services: Medical Examination And Evaluation
92014	Ophthalmological Services: Medical Examination And Evaluation

Provider Type

- Effective with dates of service on or after January 1, 2006 the following CPT codes have been added to provider type 10 (Podiatrist):

  20610 - Arthrocentesis, aspiration and or injection, small joint or bursa (eg., fingers, toes)

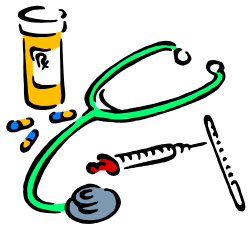
  95903 - Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study

  95904 - Nerve conduction, amplitude and latency/velocity study, each nerve; sensory, without F-wave study

- Effective with dates of service on or after January 1, 2005 the CPT code has been added to provider type 10 (Podiatrist):

  27606 - Tenotomy, Percutaneous, Achilles Tendon (Separate Procedure)

- Effective with dates of service on or after January 01, 2004 the CPT code Q0137 (Injection, Darbepoetin Alfa, 1 Mcg (Non-ESRD Use)) can be reported by provider type 08 (MD physician).



Limit(s) Changed

The codes G0108 & G0109 (Diabetes Outpatient Self-Management Training Services) have been updated to the following:

Procedure daily limit = 20

Frequency =1 year

For the purpose of clarification, providers are allowed to bill for 20, 30 minute sessions per year, for each member receiving diabetic self-management training services.

Code Updates

Effective with dates of service July 1, 2006 the codes below have been added to RF606, (Excluded Services for ESP and FES):

K0733 – Power Wheelchair Accessory, 12-14 Amp Hour Sealed

K0734 - Skin Protection Wheelchair Seat Cushion Adj. Width

K0735 - Skin Protection Wheelchair Seat Cushion Adj. 22 In Or Greater

K0736 - Skin Protection/Positioning Wheelchair Seat Cushion Adj.

K0737 - Skin Protection And Positioning Wheelchair Seat Cushion

Prior Authorization

Effective with dates of service on or after January 1, 2006 the code A5500 (For Diabetics Only, Fitting (Including Follow-Up)), has been changed in the reference screen RF 124 (Procedure Prior Authorization). The code has been changed from 03, (PA Required, for both acute and LTC) to 04, (PA Not Required, for Acute and LTC).

Anesthesia Base Units

Effective with dates of service on or after January 1, 2006 have been changed. The anesthesia base units changes are as follows:

Procedure Code	Description	Change(s)
00537	Anesthesia For Cardiac Electrophysiologic Procedures Includ-	10 base units
00540	Anesthesia For Thoracotomy Procedures Involving Lungs, Pleur A, Diaphragm,	12 base units
00797	Anesthesia For Intraperitoneal Procedures In Upper Abdomen Including	10 base units
01916	Anesthesia For Diagnostic Arteriography/Venography	5 base units
01963	Anesthesia For Cesarean Hysterectomy Without Any Labor Analgesia/Anesthesia	10 base units
99100	Anesthesia For Patient Of Extreme Age, Under One Year And Over Seventy (List Separately)	1 base unit
99116	Anesthesia Complicated By Utilization Of Total Body Hypo-thermia	5 base units
99135	Anesthesia Complicated By Utilization Of Controlled Hy-potension	5 base units
99140	Anesthesia Complicated By Emergency Conditions (Specify)	2 base units

CN1 Data

Listed below is the revised CN1 data for the subcap code crosswalk

CN1	DEFINITION RCP EXP	SUB CAP	DESCRIPTION
Blank		00	No subcapitated payment arrangement. Used to report services paid on a fee-for-service basis. When subscriber exception code is 25, subcap code is 05.
01	Diagnosis Related Group (DRG)	00	Full subcapitation arrangement. Used to report services provided under a fully subcapitated contractual arrangement. When subscriber exception code is 25, subcap code is 05.
02	Per Diem	00	Full subcapitation arrangement. Used to report services provided under a fully subcapitated contractual arrangement. When subscriber exception code is 25, subcap code is 05.
03	Variable Per Diem	00	Full subcapitation arrangement. Used to report services provided under a fully subcapitated contractual arrangement. When subscriber exception code is 25, subcap code is 05.
04	Flat	00	Full Subcapitation arrangement. Used to report services provided under a fully subcapitated contractual arrangement. When subscriber exception code is 25, subcap code is 05
05	Capitated	01	Full subcapitation arrangement. Used to report services provided under a fully subcapitated contractual arrangement. When subscriber exception code is 25, subcap code is 05
06	Percent	00	Partial subcapitation arrangement. Used to report services provided by a subcapitated provider that are excluded from the subcapitated payment arrangement. When subscriber exception code is 25, subcap code is 05
09	Other	08	Negotiated settlement. Used to report services that are included in a negotiated settlement, for example, claims paid as part of a grievance settlement, when subscriber exception code is not 25.
09	Other	04	Contracted transplant service (covered under AHCCCSA catastrophic reinsurance) Used to report covered transplant services paid via catastrophic reinsurance, when subscriber exception code is 25.
	Identified by Filename	06	Denied claim used to report valid AHCCCS services that are denied. For example, if a claim was denied for untimely submission.

Out Patient Fee Schedule (OPFS) Reminder

Just a reminder that the Exceptions to Surgical Bundling as outlined on RF739/REF03 P1 table apply only to those claims where the bundling qualifier is Surgical. There are no exceptions to bundling for those claims where ER is the only bundling qualifier.

Out Patient Fee Schedule (OPFS)

AHCCCS has made the following changes to our OPFS Observation Service Billing Requirements effective 7/1/2006 to clarify in response to Hospital and Health Plan concerns, and to ensure more consistency with Medicare requirements for like services.

Beginning with dates of service 7/1/2006 and after, Observation Services must be billed with the appropriate revenue code 721 or 762, and HCPCS procedure code G0378, (Hospital observation service, per hour); units reported should be hourly.

The revised FFS Provider Manual Section outlines this billing requirement. This information can be found on the AHCCCS website: http://www.azahcccs.gov/Publications/GuidesManuals/provman/index.asp

Medicare Billing Guidelines - 1500 Form

From: National Medicaid HIPAA Work Group [mailto:NAMEDIWORK-L@LIST.NIH.GOV] **On Behalf Of** SHUGART, ALAN
Sent: Thursday, August 03, 2006 5:04 AM
To: NAMEDIWORK-L@LIST.NIH.GOV
Subject: Medicare Billing Guidelines for 1500 form

**** National Medicaid EDI Healthcare (NMEH) Mailing List ****

The website listed below is from an article that was released by CMS establishing the basic Medicare billing requirements necessary to implement the new Health Insurance Claim Form (CMS1500 Form). The new form implementation timeline and the requirements to use the NPI on paper forms, starting May 23rd 2007.

http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5060

The following is from the **National Medicaid EDI Healthcare (NMEH) Mailing List**

This is the language in the bill that adopts no later than April 1, 2007 ASC X12 5010 as the HIPAA standard transactions, the ICD-10, and the NCPDP C.3. The compliance date for 5010 and NCPDP is April 1, 2009 and for ICD-10 is October 1, 2009.

SEC. 5. RULEMAKING TO UPGRADE ASC X12 AND NCPDP STANDARDS AND ICD CODES.

(a) In General- Not later than April 1, 2007, the Secretary of Health and Human Services shall promulgate a final rule under section 1174(b) of the Social Security Act (42 U.S.C. 1320d-3(b)) to provide for the following modification of standards:

(1) ACCREDITED STANDARDS COMMITTEE X12 (ASC X12) STANDARD- The replacement of the Accredited Standards Committee X12 (ASC X12) version 4010 adopted under section 1173(a) of such Act (42 U.S.C. 1320d-2(a)), including for purposes of part A of title XVIII of such Act, with the ASC X12 version 5010, as reviewed by the National Committee on Vital Health Statistics.

(2) NATIONAL COUNCIL FOR PRESCRIPTION DRUG PROGRAMS (NCPDP) TELECOMMUNICATIONS STANDARDS- The replacement of the National Council for Prescription Drug Programs (NCPDP) Telecommunications Standards version 5.1 adopted under section 1173(a) of such Act (42 U.S.C. 1320d-2(a)), including for purposes of part A of title XVIII of such Act, with NCPDP Telecommunications Standards version C.3, as approved by such Council and reviewed by the National Committee on Vital Health Statistics.

(3) ICD CODES- The replacement of the International Statistical Classification of Diseases and Related Health Problems, 9th revision, Clinical Modification (ICD-9-CM) under the regulation promulgated under section 1173(c) of such Act (42 U.S.C. 1320d-2(c)), including for purposes of part A of title XVIII of such Act, with both of the following:

(A) The International Statistical Classification of Diseases and Related Health Problems, 10th revision, Clinical Modification (ICD-10-CM).

(B) The International Statistical Classification of Diseases and Related Health Problems, 10th revision, Procedure Coding System (ICD-10-PCS).

(b) Rule of Construction- Nothing in subsection (a)(3) shall be construed as affecting the application of classification methodologies or codes, such as CPT or HCPCS codes, other than under the International Statistical Classification of Diseases and Related Health Problems (ICD).

(c) Notice- Not later than 30 days after the date of the enactment of this Act, the Secretary of Health and Human Services shall publish in the Federal Register a notice of the requirements to promulgate final rules under subsection (a). Such notice shall include--

(1) the respective date by which each such rule must be promulgated under such subsection;

(2) the respective compliance date described in subsection (e) for each such rule; and

(3) a statement that entities covered under the Health Insurance Portability and Accountability Act of 1996 and health information technology vendors should plan for the implementation of upgraded ASC X12, NCPDP, and ICD codes under such subsection.

(d) No Judicial Review- The final rules promulgated under subsections (a) shall not be subject to judicial review.

(e) Compliance With Upgraded Standards- For purposes of section 1175(b)(2) of the Social Security Act (42 U.S.C. 1320d-4(b)(2))--

(1) ASC X12 AND NCPDP STANDARDS- The final rules promulgated under paragraphs (1) and (2) of subsection (a) shall apply to transactions occurring on or after April 1, 2009.

(2) ICD CODES- The final rule promulgated under paragraph (3) of subsection (a) shall apply to transactions occurring on or after October 1, 2009.

New CMS NPI Tips document, #4366

A new NPI Tips document has been recently released by CMS "Tips for Health Care Professionals – Preparing Your Office Staff for NPI". The website is: http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/EducatingCMSProviders4-24-06.pdf

On May 1, 2006, the Centers for Medicare & Medicaid Services (CMS) introduced the revised CMS 855 Medicare provider enrollment applications. As part of the revised enrollment process, initial enrollees and existing enrollees making changes to their enrollment information must include their National Provider Identifier (NPI) number and a copy of the National Plan and Provider Enumeration System (NPPES) NPI notification with the enrollment application. No initial application can be approved and no updates to existing enrollment information can be made without this NPI information. All health care providers and suppliers who bill Medicare are required to obtain their NPI in advance of enrolling in or changing their Medicare enrollment data.

If you are an individual or sole proprietor, who furnishes health care, you are eligible for one and only one NPI. If you are an individual who is a health care provider and who is incorporated, you may need to obtain an NPI for yourself and an NPI for your corporation or LLC. If you are an organization that furnishes health care, you may determine that you have components, called "subparts," that need their own NPI. For additional information about the NPI, please go to: http://www.cms.hhs.gov/NationalProvIdentStand/

If you have not yet obtained your NPI number, CMS encourages you to do so soon even if you are not enrolling or making a change to your Medicare enrollment information. Attached is an information sheet designed to provide basic information about the NPI, including the three different ways to apply for your NPI. Whatever method you use to obtain your NPI, be sure to keep this information, share it with your health care partners, and update your information with NPPES whenever any of the information used to get your NPI changes.

Starting May 23, 2007, the NPI will replace all of your existing provider numbers that you use to bill Medicare, Medicaid, and other health care payers. Although this date is about a year away, you should begin sharing this information with Medicare, other payers, and your other health care partners in order to make the transition to NPI as smooth as possible. For more information about the revised provider enrollment process, please contact your Medicare contractor or go to http://www.cms.hhs.gov/MedicareProviderSupEnroll.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Beneficiary Choices
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CENTER FOR BENEFICIARY CHOICES

Date: April 11, 2006
To: All Part D Sponsors
From: Abby Block, Director

Subject: CMS Clarification of Coverage of Prescription Niacin Under Part D On February 3, 2006, we sent a letter to Part D plans explaining our view that prescription Niacin products (Niaspan®, Niacor®) are prescription vitamins and therefore excluded from the definition of a Part D drug under the statute. We have reviewed this issue more closely. The prescription niacin products Niaspan® and Niacor® are approved by the Food and Drug Administration as safe and effective drugs, are used therapeutically for the treatment of dyslipidemia, and do not serve as nutritional supplements or address a vitamin deficiency. These products are used at dosages much higher than appropriate for nutritional supplementation. For these reasons, we have concluded that these products should not be considered prescription vitamins for purposes of Part D coverage, and therefore, are not universally excluded from coverage under the Medicare prescription drug program.

Application of Policy Clarification to Contract Year 2006

This policy clarification supersedes our February 3, 2006 letter. However, because we had initially identified prescription niacin products as excluded, and plans may have relied on this communication, we do not believe that plans should now be required to add these drugs to their formularies. Thus, plans will have the option to begin covering these drugs immediately and, if so, should submit the additions to the HPMS and Medicare Prescription Drug Plan Finder formulary files with the next available upload periods. Plans that previously notified enrollees that prescription niacin products would be removed from their formularies, but that now intend to cover these products, should update their enrollees through the "upcoming Formulary change section" of the Explanation of Benefits (EOB) document.

Application of Policy Clarification to Contract Year 2007

For contract year 2007 formularies, prescription niacin products used at dosages much higher than appropriate for nutritional supplementation should be considered for formulary inclusion similar to all other Part D drugs. As outlined in the Final Formulary Guidance for 2007, we will review formularies for appropriate access to drugs and drug classes addressed in widely accepted treatment guidelines, including the guidelines for lipid disorders

NPI: Get It. Share It. Use It.

As the industry transitions to NPI compliance, remember that there is no charge to get an NPI. Providers can apply online for their NPI, free of charge, by visiting https://nppes.cms.hhs.gov or by calling 1-800-465-3203 to request a paper application. The CMS NPI page, located at http:\\www.cms.hhs.gov\NationalProvIdentStand\, is the only source for official CMS education and information on the NPI initiative; all products located on this site are free of charge.

CMS continues to urge providers to include legacy identifiers on their NPI applications, not only for Medicare but for all payors. If reporting a Medicaid number, include the associated State name. If providers have already applied for their NPI, CMS asks them to go back into the NPPES and update their information with their legacy identifiers. This information is critical for payors in the development of crosswalks to aid in the transition to the NPI.

REMINDER: The National Plan and Provider Enumeration System (NPPES) will be down for scheduled maintenance on August 2nd and 3rd , and will return to operation on August 4th after 8:00 a.m., Eastern Time.

Getting an NPI is free - not having one can be costly.

Email Updates

If and when you change your E-mail address, please contact the AHCCCS workgroup along with the Encounter Unit. This information should be sent as soon as possible so that there is no distribution of work.